



Medical History Information

Child's full name: _____ Date: _____

Name used: _____ Date of Birth: _____ Due Date: _____

Birth Weight: _____ Length: _____ Type Delivery: _____

Apgar Scores (If Known): _____ Blood Type of: Mother _____ Infant _____

City of birth: _____ Illness or Medications in Pregnancy: _____

Illness in Newborn Period: _____

Has Your Child had any of the following?

____ Asthma ____ Ear Infection ____ Chicken Pox _____ (Year) ____ Allergies ____ Pneumonia
____ Bronchitis ____ Urinary Tract Infection ____ Other Illnesses/ Problems: _____

Hospital stays/surgeries: _____

Is your child allergic to any medications or foods? Y N

Please list allergies: _____

Are immunizations up to date: ____ Yes ____ No ____ Not Sure

Who lives in the household with the Child: ____ Mother ____ Father ____ Stepmother ____ Stepfather
____ Siblings ____ Grandparents ____ Stepsiblings ____ Boyfriend/Girlfriend of parent ____ Other: _____

FAMILY HISTORY

Mother's Name: _____ Age: _____ Health: _____

Father's Name: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Do any family members have the following? If so, whom?

Allergies: _____ Asthma: _____ Blood/Bleeding Disorders: _____

Diabetes: _____ Early Heart Disease: _____

Miscarriages: _____ Mental Retardation: _____

Seizures: _____ Tuberculosis: _____

For Office Use Only:
Date: _____
Initials: _____